

97CV3826-EHN-MJ

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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GLADYS DIAZ,

97 CV 3826

Plaintiff,

MEMORANDUM

AND

-against-

ORDER

KENNETH S. APFEL, COMMISSIONER,
SOCIAL SECURITY ADMINISTRATION,

Defendant.

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BINDER & BINDER

(Charles E. Binder, of counsel)
1393 Veterans Memorial Highway
Suite 210 North
Hauppauge, New York 11788
for plaintiff.

ZACHARY W. CARTER, United States Attorney
Eastern District of New York
One Pierrepont Plaza
Brooklyn, New York 11201
for defendant.

NICKERSON, District Judge:

Gladys Diaz, by her attorney, brought this action
pursuant to 42 U.S.C. § 405(g) to review a final
decision by the defendant Commissioner of Social

Security that she is not entitled to disability insurance benefits under the Social Security Act.

I

Plaintiff filed her application for disability insurance benefits on December 29, 1993. The Commissioner denied this application initially and on reconsideration.

Plaintiff then requested a hearing, which was held on June 1, 1995. In a decision dated October 27, 1995 the Administrative Law Judge determined that claimant was not disabled within the meaning of the Social Security Act. The Appeals Council denied plaintiff's request for review on May 8, 1997, and this action followed.

II

The Administrative Law Judge made the following formal findings.

Plaintiff was 59 years old at the time of the hearing, and graduated from high school in the

Dominican Republic. She came to the United States in 1962, and attended hairdressing school in 1970.

Plaintiff worked from 1977 to 1987 as a school crossing guard, and held a second job as a cleaning lady from 1979 to 1987.

Plaintiff alleges that she has been disabled since December 2, 1987 due to injuries sustained in a motor vehicle accident. In the accident, plaintiff fractured her ankle, dislocated her shoulder, and hit her head, causing her to suffer some memory loss. She has not engaged in substantial gainful activity since the accident.

Plaintiff testified that she is able to cook dinner, wash dishes, and read. She has two children, aged twenty-six and twenty-three.

The Administrative Law Judge determined that plaintiff was capable of performing her past relevant work as a school crossing guard, and therefore was not disabled for purposes of entitlement to disability insurance benefits.

III

The medical evidence shows that on December 2, 1987 plaintiff, while working as a school crossing guard, was struck on the right side of her body by a car. She was admitted to Bronx Municipal Hospital Center for treatment of a fractured right distal fibula and a fractured acromioclavicular joint. Plaintiff's right lower leg was placed in a cast and her right arm was placed in a sling. Plaintiff was discharged from the hospital on December 4, 1987.

On January 20, 1988 an x-ray of plaintiff's right distal fibula showed that the fracture was healing.

Plaintiff received physical therapy for her right shoulder at Bronx Municipal Rehabilitation Center. On May 12, 1988 her shoulder was reevaluated. Plaintiff complained of difficulty with activities that require internal rotation of her right shoulder. The therapist noted that plaintiff had increased ranges of motion, was able actively to flex her shoulder to 155 degrees, abduct to 160 degrees, and rotate internally to seventy-five degrees. These values represented a five

degree rise from the previous findings in each category. Plaintiff's passive ranges of motion also increased: shoulder flexion increased twenty degrees to 160 degrees; abduction was 165 degrees, an increase of twenty-five degrees; and internal rotation rose thirty degrees.

The therapist noted that plaintiff's proximal muscle strength continued to be good, and her hand strength was normal. She exhibited pain only upon extremes of movement. She continued to have difficulty with activities requiring internal rotation.

Plaintiff returned for therapy on June 13, 1988. She complained of moderate shoulder pain which varied with the weather, and of pain in her back. Plaintiff's ability actively to rotate her shoulder internally increased to eighty degrees, a twenty degree improvement over the previous figure. She was able to rotate externally to ninety degrees. The therapist noted decreases in shoulder flexion of twenty degrees and in abduction of fifty degrees. Plaintiff's shoulder strength continued to be good. Flexion and

extension of the elbow were normal. She still had difficulty with internal rotation. Plaintiff was following a home program to increase ranges of motion and joint mobilization.

Dr. Bruce Topper examined x-rays of plaintiff's lumbosacral spine on August 8, 1988. The x-rays revealed a normal lordosis, normal vertebral bodies, and showed no fractures or spondylolisthesis.

Plaintiff was discharged from therapy on August 15, 1988 because she had "completed goals." She reported that the pain in her right shoulder decreased to a minimum. She continued to complain of pain in her back and right leg. The therapist noted that plaintiff has experienced "significant" increases in her range of motion, that she was independent in all areas of daily living, and that the "problem [was] resolved." Plaintiff had also achieved a two-grade increase in strength. Plaintiff was instructed to continue the home program of strengthening and functional activities.

On June 13, 1989, plaintiff began medical treatment with Dr. Robert Zaretsky, an orthopedist and plaintiff's treating physician. He treated plaintiff for her back condition on at least twenty occasions.

During his initial examination of plaintiff, Dr. Zaretsky noted a moderate muscle spasm in the back and spine. He performed an electromyogram with normal results. Plaintiff experienced tenderness at the L4-S1 level along the midline. She was able to flex her trunk to fifty-five degrees, extend to ten degrees, and bend laterally to fifteen degrees. Straight leg raising was negative. Knee and ankle reflexes were normal bilaterally, and the doctor noted no signs of atrophy.

Upon examination of the right ankle, Dr. Zaretsky noted tenderness at the medial/lateral joint lines, with mild swelling. Dorsiflexion of plaintiff's right ankle was to five degrees, and plantar flexion was to seven degrees. Inversion and eversion were mildly limited. X-rays of the right ankle revealed no evidence of fracture. Plaintiff had full range of

motion in the shoulder joint, with no atrophy. Based on his first examination of her, Dr. Zaretsky opined that plaintiff suffered from a partial disability related to residuals of a sprain of the lumbosacral spine and a fracture of the right ankle, with residual stiffness.

Dr. Zaretsky examined plaintiff a second time on July 11, 1989. She complained of lumbosacral pain and forgetfulness. On examination, Dr. Zaretsky noted moderate lumbar spasm. Lumbar flexion was possible to fifty-five degrees, and lateral bending was to fifteen degrees. Straight leg raising was negative, and reflexes were normal. Plaintiff was prescribed Tuma Compound tablets.

Plaintiff was reexamined by Dr. Zaretsky on August 16, September 20, November 1, and December 6, 1989. She complained of lower back pain associated with moderate spasm and tenderness. Plaintiff's ranges of motion were similar to those of her July 11 visit, and her condition remained essentially unchanged.

Dr. Zaretsky next examined plaintiff one year later, on December 3, 1990. Plaintiff complained of lower back pain and headaches. Examination revealed that plaintiff could flex her lumbar spine to fifty-five degrees, and extend and bend laterally to ten degrees. Straight leg raising was negative, and reflexes were present. Plaintiff underwent a CAT Scan on December 12, 1990, which showed a first degree spondylolisthesis at L4-L5 on a degenerative basis. Moderate degenerative changes were present predominately involving both zygapophysial joints at L4-L5. There was no evidence of disc herniation.

Plaintiff was re-examined by Dr. Zaretsky on January 10 and February 7, 1991. During this time she continued to exhibit paravertebral muscle spasm with limited flexion to fifty degrees, and extension and lateral flexion to ten degrees. Neurological examination remained within normal limits. Plaintiff was given another prescription for Soma Compound tablets.

Dr. Zaretsky saw plaintiff again on March 19, April 16, and May 15, 1991. Plaintiff still suffered from muscle spasm. Her lumbar flexion was to thirty-five degrees, extension to ten degrees, and lateral bending to thirty-five degrees. Straight leg raising was negative, and reflexes were normal.

Dr. Zaretsky noted similar results when he examined plaintiff on June 25, August 16, and September 12, 1991. Plaintiff was still symptomatic, complaining of lower back pain. Physical examination revealed a mild spasm on motion. Forward flexion of plaintiff's lumbar spine was to forty degrees, extension to ten degrees, and lateral bending to twenty degrees. Straight leg raising was negative. Reflexes were intact.

On plaintiff's October 30 and December 30, 1991 visits, Dr. Zaretsky noted no changes in his physical findings. On her January 22 and February 12, 1992 visits plaintiff was able to flex her lumbar spine forward to thirty degrees, extend to five degrees, and bend laterally to twenty degrees. Reflexes were

normal, and straight leg raising was negative. On March 4, March 25, and April 22, 1992, lumbar flexion was to forty degrees, extension to ten degrees, and lateral bending to twenty degrees.

Plaintiff's final visit to Dr. Zaretsky was on January 19, 1994, shortly after her application for disability insurance was filed. She complained of pain involving the lumbosacral spine. Dr. Zaretsky found paravertebral muscle spasm with flexion at thirty degrees, extension at five degrees, and lateral bend at five degrees to the right and left. Straight leg raising was positive on the right side. Reflexes were present.

In a letter dated May 31, 1994, Dr. Zaretsky opined that the plaintiff is disabled and unable to perform gainful employment. He noted that she has a limited capacity for lifting, standing, sitting, and walking. He reported that plaintiff was able to sit for twenty minutes, stand for fifteen to twenty minutes, and walk for twenty minutes without interruption. During an eight-hour workday, plaintiff

could sit for a total of three hours, stand for two hours, and walk for one hour. He based these findings on "(1) spondylolisthesis--painful, (2) arthritis of spine, (3) muscle spasm with limited motion." Dr. Zaretsky reported that plaintiff could occasionally lift and carry between six and ten pounds. Plaintiff was not limited in her ability to grasp, push, pull, or perform fine or gross manipulations. She was not able to operate a foot control, bend, crawl, or climb, and could only occasionally squat or reach.

Significantly, Dr. Zaretsky's notes and reports detailed how plaintiff's condition deteriorated. By January of 1994, for example, she had only thirt degrees flexion and five degrees in extension and lateral bending, whereas in his first examination of plaintiff Dr. Zaretsky found flexion to be fifty-five degrees, extension ten degrees, and lateral bending fifteen degrees. By 1994 straight leg raising, which had originally been negative, had become positive on the right side.

Plaintiff underwent a consultative examination with Dr. K. Seo on February 15, 1994. Dr. Seo noted that plaintiff walked with a normal gait, had no difficulty standing from a seated position, or getting on or off of the examination table. Plaintiff had a normal cervical lordosis, and normal range of motion in her cervical spine. Dr. Seo noted no muscle spasms. Plaintiff had full motion in both shoulders. Although elevation of the right shoulder elicited pain, there was no evidence of subcutaneous creptiation, or frozen shoulder. Ranges of motion in the elbows and wrists were normal. Reflexes were one-plus in her arm. No sensory defect was noted, and the fine motor coordination of both hands was normal. Plaintiff had full muscle strength in her hands and arms.

Dr. Seo reported that plaintiff flexed her lumbar spine forward to thirty degrees, and rotated laterally and flexed to fifteen degrees respectively. Lumbar extension was zero degrees, and plaintiff had no muscle spasms in the muscles surrounding her lumbar spine. Plaintiff exhibited normal motion in her hips, knees,

and ankles. The length of her legs was even, and there was no muscle atrophy of the thigh or lower leg.

Babinski, Oppenheim, and ankle clonus tests were negative. Plaintiff had diminished sensation of the right leg, at the L4-L5 and S1 levels. Straight leg raising in the supine position was positive to twenty degrees on the right, and to thirty degrees on the left. Straight leg raising was negative bilaterally in the sitting position. Plaintiff was able to toe-heel walk, although with back pain. She was able to squat one-quarter of the way, and had full muscle strength of both legs.

X-rays of the lumbosacral spine revealed grade I spondylolisthesis at L4-L5, and mild degenerative changes of the facet joints at L4-L5 and L5-S1. X-rays of plaintiff's right ankle showed two bony fragments, and a small calcaneal spur which the radiologist concluded were consistent with plaintiff's clinical history. Dr. Seo diagnosed degenerative osteoarthritis of the thoracolumbar vertebra, with thoracolumbar scoliosis, and mild arthralgia of the right shoulder

due to plaintiff's past injury. Functionally, Dr. Seo opined that plaintiff would only have difficulty bending down, or lifting and carrying heavy objects.

Plaintiff also underwent a consultative evaluation with Dr. Stanley Ross on May 23, 1994. Dr. Ross noted that plaintiff stood easily from a seated position and walked normally. She had a full range of cervical motion, a firm grasp, and normal gross and fine manipulative coordination. Lateral bending was normal, but plaintiff complained of discomfort across the lower back into the upper back when she flexed forward to fifty percent. Straight leg raising was negative bilaterally when sitting. Dr. Ross noted no neurological deficits in plaintiff's legs. Knees and ankles reflexes were normal bilaterally. When prone, plaintiff had tenderness in the lumbosacral junction with mild spasm in both flanks radiating into the dorsal scapular area. Additionally, both arms and legs functioned normally.

Dr. Ross opined that plaintiff would have difficulty bending or lifting heavy objects. She was

able to sit and stand normally, and could perform gross and fine manipulative activities with both hands.

IV

The Commissioner's findings of fact are conclusive if supported by substantial evidence. See Rutherford v. Schweiker, 685 F.2d 60, 62 (2d Cir. 1982). The Court must also determine whether the claimant has had a "full hearing" as required by the regulations. Cruz v. Sullivan, 912 F.2d 8, 11 (2d Cir. 1990).

For purposes of Supplemental Security Income benefits, an individual shall be considered disabled if she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to last for a continuous period of not less than 12 months. 42 U.S.C. § 423(d)(1)(A). The physical or mental impairment must be so severe that the individual "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work

which exists in the national economy." 42 U.S.C. § 423 (d) (2) (A) .

The Administrative Law Judge concluded that the plaintiff has a "severe impairment," but found that she could go back to work as a school crossing guard. In reaching this determination, the Administrative Law Judge rejected the opinion of plaintiff's treating physician, an expert in the field of orthopedics who examined plaintiff over twenty times. Instead, the Administrative Law Judge relied on his own impression based on one meeting with the plaintiff that "the claimant walked normally, sat easily and rose effortlessly," finding that plaintiff's "capacity to sit, stand, walk and use her arms and hands is not significantly restricted."

This determination improperly discounts the five years over which Dr. Zaretsky treated plaintiff, and the multiple MRIs, x-rays, CAT scans, and physical examinations performed by him during that time. Certainly there were ample objective medical facts from

which Dr. Zaretsky could fairly have concluded that she suffered from disabling pain.

Dr. Seo, one of the consultants, was not an orthopedist. Dr. Ross, the other consultant, was apparently not supplied with any of Dr. Zaretsky's reports or with the MRIs and x-rays. Moreover, the Administrative Law Judge was "persuaded" not only by his own view that plaintiff in his office showed "no limitations" in "sitting, walking or standing," but also by written reports of two doctors of unknown qualifications, who had never even seen plaintiff and who were allocated twenty minutes "to read the instructions [on the reporting form], gather the necessary facts, and fill out the form."

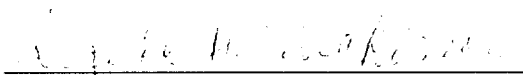
The determination of a treating physician is entitled to greater respect than this. Indeed, it is entitled to controlling weight if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record. 20 C.F.R. § 404.1527(d)(2). Dr. Zaretsky's opinion should be given

controlling weight in this case since there was no substantial evidence to refute it.

The decision of the Administrative Law Judge was not based on substantial evidence. Plaintiff proved that she has been disabled since December 2, 1987. The case is remanded for the calculation of benefits.

So ordered.

Dated: Brooklyn, New York
August , 1998



Eugene H. Nickerson, U.S.D.J.